

Kirk A. Cullimore proposes the following substitute bill:

Health Provider Directory and Access Amendments

2026 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Steve Eliason

Senate Sponsor: Kirk A. Cullimore

LONG TITLE

General Description:

This bill addresses provider directories and timely access to behavioral health services.

Highlighted Provisions:

This bill:

▸ requires covered insurers to:

- assist enrollees in accessing behavioral health services in a timely manner;
- facilitate an insured obtaining behavioral health services from an out-of-network provider if an in-network provider is not available in a timely manner;
- publish health care provider directories;
- regularly update health care provider directories; and
- take certain steps to ensure the accuracy of provider directories;

▸ authorizes Utah's insurance commissioner (commissioner) to make rules to implement certain provisions of this bill;

▸ requires providers to respond to an insurer's request for verification of provider directory information within a certain period of time;

▸ requires insurers and the commissioner to issue an educational letter to a provider that demonstrates a pattern of violations of certain provisions;

▸ requires the Division of Professional Licensing to convene a working group to study the feasibility and cost of creating and maintaining a statewide behavioral health provider directory (working group) and report to the Health and Human Services Interim Committee;

▸ provides a repeal date for the working group; and

▸ defines terms.

Money Appropriated in this Bill:

None

29 **Other Special Clauses:**

30 None

31 **Utah Code Sections Affected:**

32 AMENDS:

33 **63I-2-258**, as last amended by Laws of Utah 2025, Chapter 277

34 ENACTS:

35 **31A-22-663**, Utah Code Annotated 1953

36 **31A-22-664**, Utah Code Annotated 1953

37 **58-1-113**, Utah Code Annotated 1953

38

39 *Be it enacted by the Legislature of the state of Utah:*

40 Section 1. Section **31A-22-663** is enacted to read:

41 **31A-22-663 . Timely access to behavioral health services -- Single case agreement.**

42 (1) As used in this section:

43 (a) "Covered insurer" means an insurer that offers health insurance that includes
44 coverage for behavioral health services.

45 (b)(i) "Behavioral health services" means:

46 (A) mental health treatment or services; or

47 (B) substance use treatment or services.

48 (ii) "Behavioral health services" includes telehealth services and telemedicine
49 services.

50 (c) "Insurer" means the same as that term is defined in Section 31A-22-634.

51 (d) "Mental health provider" means the same as that term is defined in Section
52 31A-22-658.

53 (e) "Telehealth services" means the same as that term is defined in Section 26B-4-704.

54 (f) "Telemedicine services" means the same as that term is defined in Section 26B-4-704.

55 (g) "Timely manner" means:

56 (i) no more than 15 days after the day on which an insured first attempts to access
57 behavioral health services; and

58 (ii) no more than 24 hours after the date and time that an insured first seeks to access
59 urgent, emergency, or crisis behavioral health services.

60 (2) Beginning January 1, 2027, a covered insurer shall:

61 (a) establish a procedure to assist an enrollee to access behavioral health services from
62 an out-of-network mental health provider when no in-network mental health provider

- 63 is available in a timely manner; and
- 64 (b) if an enrollee in a covered insurer's health benefit plan is unable to obtain covered
65 behavioral health services from an in-network mental health provider in a timely
66 manner, enter into a single case agreement that allows the enrollee to receive covered
67 behavioral health services from an out-of-network mental health provider.
- 68 (3)(a) A covered insurer shall include in a negotiated single case agreement described in
69 Subsection (2)(b):
- 70 (i) a requirement that the covered insurer reimburse the out-of-network mental health
71 provider for the covered behavioral health services at a rate negotiated by the
72 provider and insurer, subject to the member cost-sharing requirements imposed by the
73 health benefit plan;
- 74 (ii) a requirement that the covered insurer apply the same coinsurance, copayments,
75 and deductibles that would apply for the behavioral health services if the
76 behavioral health services were provided by a mental health provider that is an
77 in-network mental health provider;
- 78 (iii) any terms that a network provider is subject to under the health benefit plan; and
79 (iv) the length and scope of the single case agreement.
- 80 (b) Notwithstanding Subsection (3)(a)(ii):
- 81 (i) a covered insurer's payment under a single case agreement described in Subsection
82 (2)(b) constitutes payment in full to the provider for the behavioral health services
83 the enrollee receives; and
- 84 (ii) the provider may not seek additional payment from the enrollee except for
85 applicable cost sharing.
- 86 (4) A covered insurer shall ensure that a single case agreement described in Subsection
87 (2)(b) only permits an insured to receive behavioral health services:
- 88 (a) that are:
- 89 (i) within the out-of-network mental health provider's scope of practice; and
90 (ii) behavioral health services that are otherwise covered under the enrollee's health
91 benefit plan; and
- 92 (b) that are not experimental, unless the insurer covers experimental treatments for
93 physical health conditions in compliance with the Mental Health Parity and
94 Addiction Equity Act, Pub. L. No. 110-343.
- 95 (5) A covered insurer shall:
- 96 (a) document all payments the covered insurer makes under a health benefit plan to a

- 97 mental health provider under this section; and
- 98 (b) provide the documentation described in Subsection (5)(a) to the department upon
- 99 request.
- 100 (6) Subsections (2)(b), (3), and (4) do not apply if behavioral health services are available
- 101 in a timely manner.
- 102 (7) The commissioner may:
- 103 (a) make rules in accordance with Title 63G, Chapter 3, Utah Administrative
- 104 Rulemaking Act, to implement this section; and
- 105 (b) bring an action in accordance with Section 31A-2-308 and Title 63G, Chapter 4,
- 106 Administrative Procedures Act, for a violation of this section.
- 107 Section 2. Section **31A-22-664** is enacted to read:
- 108 **31A-22-664 . Health care provider directories.**
- 109 (1) As used in this section:
- 110 (a) "Division" means the Division of Professional Licensing created in Section 58-1-103.
- 111 (b) "Exempt health care professional" means a person exempt from licensure under a
- 112 title listed in Subsection 58-13-3(2)(c).
- 113 (c) "Exempt mental health provider" means an individual exempt from licensure under
- 114 Section 58-60-107.
- 115 (d) "Health care facility" means the same as that term is defined in Section 26B-2-201.
- 116 (e) "Health care professional" means the same as that term is defined in Section 58-13-3.
- 117 (f) "Hospital" means a facility licensed under Title 26B, Chapter 2, Part 2, Health Care
- 118 Facility Licensing and Inspection, as a general acute hospital or specialty hospital.
- 119 (g) "Insurer" means the same as that term is defined in Section 31A-22-634.
- 120 (h) "Mental health provider" means the same as that term is defined in Section
- 121 31A-22-658.
- 122 (i) "Pharmacy" means the same as that term is defined in Section 58-17b-102.
- 123 (j) "Provider" means:
- 124 (i) a health care professional;
- 125 (ii) an exempt health care professional;
- 126 (iii) a mental health provider;
- 127 (iv) an exempt mental health provider; or
- 128 (v) a pharmacy.
- 129 (k) "Provider directory" means a list of in-network providers for each of an insurer's
- 130 health benefit plans.

- 131 (l) "Telehealth services" means the same as that term is defined in Section 26B-4-704.
132 (m) "Telemedicine services" means the same as that term is defined in Section
133 26B-4-704.
- 134 (2) Beginning January 1, 2027, an insurer shall:
135 (a) publish a provider directory for each of the insurer's health benefit plans; and
136 (b) update the provider directory no less frequently than every 60 days.
- 137 (3) An insurer shall ensure that, except as provided in Subsection (7):
138 (a) a provider directory:
139 (i) is easily and publicly accessible:
140 (A) through a conspicuous link on the home page of the insurer's website; and
141 (B) without requiring an individual to create an account or submit a policy or
142 contract number; and
143 (ii) is in a format that is searchable and downloadable; and
144 (b) a provider may update the provider's information, including contact information and
145 whether the provider is accepting new patients, in the provider directory:
146 (i) electronically;
147 (ii) on the insurer's website; and
148 (iii) through a conspicuous link on the home page of the insurer's website.
- 149 (4) A provider directory shall include:
150 (a) in plain language:
151 (i) a description of the criteria the insurer used to build the health benefit plan's
152 provider network; and
153 (ii) if applicable:
154 (A) a description of the criteria the insurer used to tier health care providers;
155 (B) how the health benefit plan designates health care provider tiers or levels; and
156 (C) a notice that authorization or referral may be required to access some health
157 care providers; and
158 (b) contact information an insured or member of the public may use to report to the
159 health benefit plan inaccurate information in a provider directory, which may include:
160 (i) a phone number;
161 (ii) an email address; or
162 (iii) a link to a website or online reporting form.
- 163 (5) In addition to the information required under Subsection (4):
164 (a) a provider directory of health care professionals and exempt health care professionals

- 165 shall include:
- 166 (i) each health care professional's and exempt health care professional's:
- 167 (A) name;
- 168 (B) contact information, including:
- 169 (I) internet address, if applicable;
- 170 (II) physical address; and
- 171 (III) phone number; and
- 172 (C) specialty, if applicable;
- 173 (ii) whether the health care professional or exempt health care professional is
- 174 accepting new patients; and
- 175 (iii) whether the health care professional or exempt health care professional offers
- 176 telehealth services or telemedicine services;
- 177 (b) a provider directory of health care facilities that are hospitals shall include each
- 178 hospital's:
- 179 (i) name;
- 180 (ii) if the hospital is a specialty hospital, the specialty type;
- 181 (iii) location or locations;
- 182 (iv) accreditation status;
- 183 (v) phone number; and
- 184 (vi) internet address, if applicable;
- 185 (c) a provider directory of health care facilities other than hospitals shall include each
- 186 health care facility's:
- 187 (i) name;
- 188 (ii) type;
- 189 (iii) services provided;
- 190 (iv) location or locations;
- 191 (v) phone number; and
- 192 (vi) internet address, if applicable;
- 193 (d) a provider directory of pharmacies shall include each pharmacy's:
- 194 (i) name;
- 195 (ii) type;
- 196 (iii) services provided, including whether the pharmacy offers mail-order or specialty
- 197 pharmacy services;
- 198 (iv) location or locations;

- 199 (v) phone number; and
- 200 (vi) internet address, if applicable; and
- 201 (e) a provider directory of mental health providers and exempt mental health providers
- 202 shall include:
- 203 (i) each mental health provider's:
- 204 (A) name;
- 205 (B) contact information, including:
- 206 (I) internet address, if applicable;
- 207 (II) physical address; and
- 208 (III) phone number; and
- 209 (C) specialty, if applicable;
- 210 (ii) whether the mental health provider or exempt mental health provider is accepting
- 211 new patients; and
- 212 (iii) whether the mental health provider or exempt mental health provider offers
- 213 telehealth services or telemedicine services.
- 214 (6)(a) For purposes of Subsection (5)(a)(ii), a health care professional is accepting new
- 215 patients if an exempt health care professional who treats patients under the
- 216 supervision of the health care professional is available to see new patients.
- 217 (b) For purposes of Subsection (5)(e)(ii), a mental health provider is accepting new
- 218 patients if an exempt mental health provider who treats patients under the supervision
- 219 of a mental health provider is available to see new patients.
- 220 (7)(a) An insurer may provide, in addition to an electronic provider directory, a provider
- 221 directory in print format.
- 222 (b) An insurer shall provide a provider directory in print format to an insured upon
- 223 request of the insured.
- 224 (c) In addition to the requirements described in Subsections (4) and (5), a provider
- 225 directory in print format shall include:
- 226 (i) the internet address of the insurer's website where the insurer's electronic provider
- 227 directory is published;
- 228 (ii) the health benefit plan's customer service phone number;
- 229 (iii) a disclosure that the information in the provider directory is accurate, to the best
- 230 of the insurer's knowledge, based on the information the provider provided, as of
- 231 the date of printing; and
- 232 (iv) a notice that an insured or prospective insured should consult the health benefit

- 233 plan's electronic provider directory or call the health benefit plan's customer
234 service phone number to obtain current provider directory information.
- 235 (8) When an insurer receives a report of inaccurate information in a provider directory, the
236 insurer shall:
- 237 (a) promptly investigate the report; and
238 (b) no later than the end of the 20th business day after the day on which the insurer
239 receives the report:
- 240 (i) verify the accuracy of the information in the provider directory; or
241 (ii) for an electronic provider directory, update the inaccurate information with
242 accurate information.
- 243 (9)(a) An insurer shall take steps to ensure the accuracy of the information in a provider
244 directory, including contacting providers to verify that provider information is up to
245 date.
- 246 (b) When an insurer contacts a provider to verify the accuracy of a provider's
247 information in a provider directory, the provider shall respond to the insurer's request
248 for verification no later than 15 business days after the day on which the insurer
249 contacts the provider.
- 250 (10)(a) An insurer shall, at least annually, audit each provider directory for accuracy.
- 251 (b)(i)(A) include the two mental health specialties and four physical health
252 specialties most utilized by insureds; and
- 253 (B) include at least one specialty related to mental health; or
254 (ii) audit a reasonable sample size of providers, if the sample size includes mental
255 health providers.
- 256 (c) An insurer shall:
- 257 (i) retain documentation of each audit performed under this Subsection (10);
258 (ii) submit the audit to the commissioner upon the commissioner's request; and
259 (iii) based on the results of the audit:
- 260 (A) verify and attest to the accuracy of the information in a provider directory; and
261 (B) update inaccurate information in a provider directory with accurate
262 information.
- 263 (11)(a) An insurer shall report to the commissioner upon request on:
- 264 (i) the number of reports of inaccuracies in provider directories the insurer received;
265 (ii) the timeliness of the insurer's response to a report of inaccuracies in a provider
266 directory;

- 267 (iii) any corrective action the insurer took in response to a report of inaccuracies in a
268 provider directory;
- 269 (iv) the identity of providers that failed to timely respond to the insurer's request for
270 verification as required under Subsection (9);
- 271 (v) all audits the insurer conducted in accordance with this section; and
- 272 (vi) any other information related to provider directory accuracy the commissioner
273 considers relevant.
- 274 (b) The commissioner may request the information described in Subsection (11)(a) no
275 more frequently than annually.
- 276 (c)(i) If an insurer finds that a provider demonstrates a repeated pattern of violations
277 of Subsection (9), the insurer shall:
- 278 (A) issue an educational letter to the provider; and
- 279 (B) send a copy of the educational letter to the commissioner and the division.
- 280 (ii) If an insurer notifies the commissioner that a provider demonstrates a repeated
281 pattern of violations of Subsection (9), the commissioner shall send an educational
282 letter to the provider.
- 283 (12) An insurer, a health care facility, a hospital, or a provider that is subject to this section
284 shall comply with all applicable requirements of the No Surprises Act, 42 U.S.C. Secs.
285 300gg-111 through 300gg-139, and federal regulations adopted in accordance with that
286 act.
- 287 (13) The commissioner may make rules in accordance with Title 63G, Chapter 3, Utah
288 Administrative Rulemaking Act, to implement the provisions of this section.
- 289 (14) In addition to the penalties authorized under Section 31A-2-308, if the commissioner
290 determines that, when an insured received services under the insured's health benefit
291 plan, the insured reasonably relied on inaccurate information in a provider directory, the
292 commissioner may:
- 293 (a) if the commissioner determines that the insurer knew or reasonably should have
294 known the information was inaccurate:
- 295 (i) require the insurer to provide coverage for all covered health care services the
296 insured received; and
- 297 (ii) reimburse the insured for the amount the insured paid for the health care services
298 that exceeds what the insured would have paid if the services were delivered by an
299 in-network provider; and
- 300 (b) if the commissioner determines that the provider provided inaccurate information or

301 failed to update the information, require the insurer to reimburse the provider at the
302 in-network rate.

303 Section 3. Section **58-1-113** is enacted to read:

304 **58-1-113 . Statewide behavioral health provider database study.**

305 (1) As used in this section:

306 (a) "Accountable care organization" means a managed care organization, as defined in
307 42 C.F.R. Sec. 438, that contracts with the Department of Health and Human
308 Services under the provisions of Section 26B-3-202.

309 (b) "Behavioral health provider" means a mental health provider that provides
310 behavioral health services.

311 (c) "Behavioral health services" means:

312 (i) mental health treatment or services; or

313 (ii) substance use treatment or services.

314 (d) "Commissioner" means Utah's insurance commissioner.

315 (e) "Database" means the statewide behavioral health provider database described in
316 Subsection (2).

317 (f) "Department of Health and Human Services" means the Department of Health and
318 Human Services created in Section 26B-1-201.

319 (g) "Division of Integrated Healthcare" means the Division of Integrated Healthcare
320 created in Section 26B-1-204.

321 (h) "Insurer" means:

322 (i) an insurer as that term is defined in Section 31A-22-634;

323 (ii) an accountable care organization;

324 (iii) a behavioral health plan as that term is defined in Section 26B-3-203; or

325 (iv) for an adult who is covered through the traditional fee-for-service Medicaid
326 model in counties without Medicaid accountable care organizations or the state's
327 Medicaid accountable care organization delivery system, the Division of
328 Integrated Healthcare.

329 (i) "Mental health provider" means the same as that term is defined in Section
330 31A-22-658.

331 (j) "PEHP" means the Public Employees' Benefit and Insurance Program created in
332 Section 49-20-103.

333 (k) "Provider directory" means a provider directory created in accordance with Section
334 31A-22-664.

- 335 (l) "Telehealth services" means the same as that term is defined in Section 26B-4-704.
- 336 (m) "Telemedicine services" means the same as that term is defined in Section
- 337 26B-4-704.
- 338 (2) On or before June 30, 2026, the division shall convene a working group to study and
- 339 develop recommendations regarding the feasibility and cost of creating and maintaining
- 340 a database of behavioral health providers in the state, including:
- 341 (a) an analysis of the requirements for a statewide behavioral health provider database
- 342 that:
- 343 (i) is accessible to the public;
- 344 (ii) allows a person accessing the database to search behavioral health providers by:
- 345 (A) license status;
- 346 (B) areas of specialty the behavioral health provider provides, including treatment
- 347 of specific mental health diagnoses and disorders;
- 348 (C) insurers with which the behavioral health provider is under contract; and
- 349 (D) whether the behavioral health provider offers any or all of the following:
- 350 (I) in-person services;
- 351 (II) telehealth services; or
- 352 (III) telemedicine services;
- 353 (iii) indicates what methods of payment a behavioral health provider accepts,
- 354 including whether the behavioral health provider accepts cash only;
- 355 (iv) indicates a behavioral health provider's availability for scheduling an
- 356 appointment;
- 357 (v) for each insurer, codes by color or other method whether each behavioral health
- 358 provider in the insurer's network:
- 359 (A) is accepting new patients;
- 360 (B) requires a prospective new patient to call for availability; or
- 361 (C) is not accepting new patients;
- 362 (vi) allows an insurer to access the database and update information about behavioral
- 363 health providers in the insurer's network;
- 364 (vii) allows a behavioral health provider to access the database and update and verify
- 365 the behavioral health provider's information;
- 366 (viii) allows the division to communicate with a behavioral health provider in the
- 367 database to prompt the behavioral health provider to review and verify
- 368 information in the database;

- 369 (ix) allows the division to import information from an insurer's provider directory
370 into the database; and
- 371 (x) allows an insurer to import information about behavioral health providers in the
372 insurer's network into the insurer's provider directory; and
- 373 (b) a determination of whether existing software or technology that PEHP owns or
374 controls meets, or could be modified to meet, the requirements for the features
375 described in Subsection (2)(a).
- 376 (3) The division shall coordinate with the Department of Health and Human Services,
377 PEHP, the Insurance Department, and accountable care organizations to determine the
378 membership of the working group described in Subsection (2).
- 379 (4) The division shall present to the Health and Human Services Interim Committee, on or
380 before the date of the committee's November 2026 meeting, on the recommendations
381 described in Subsection (2).

382 Section 4. Section **63I-2-258** is amended to read:

383 **63I-2-258 . Repeal dates: Title 58.**

384 [Reserved.] Section 58-1-113, Statewide behavioral health provider database study, is
385 repealed July 1, 2027.

386 Section 5. **Effective Date.**

387 This bill takes effect on May 6, 2026.